

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY
AVERAGE WHOLESALE PRICE
LITIGATION

THIS DOCUMENT RELATES TO:
ALL ACTIONS

MDL No. 1456

Master File No. 01-CV-12257-PBS

Judge Patti B. Saris

**AFFIDAVIT OF THOMAS TRUSKY ON BEHALF OF ESTATE OF THERESA
TRUSKY**

I, Thomas Trusky, pursuant to 28 U.S.C. §1746, on oath, depose and state as follows:

1. I am a resident of Forest City, Pennsylvania. I have personal knowledge of the facts stated below.

2. I submit this affidavit in further support of my application to be appointed as a Class Representative for Class 1 of the settlement with the Track 2 defendants.

3. Since my initial contact with Marc H. Edelson, Esq. in the winter of 2009, I have been in continual contact with him in order to be kept apprised of the status of the litigation. I have also inquired as to the status of the settlements with BMS and AZ.

4. While I agreed to become a Class Representative 1 after the Track 2 settlement had been negotiated, I am aware of the terms and believe the allocation is fair. I have been updated as to the status of the approval of the settlement and understand that Class Counsel are doing everything they can to achieve the best results for the various classes of claimants.

5. This case is very important to me. We have spent a considerable sum of money over the years on medications covered by the various settlements and would like to hold the defendants responsible for any overcharges we have paid.

6. As the attached copy of Theresa's claim form demonstrates, Theresa was provided numerous times with drugs that are covered by the Track 2 settlement. While I was able to locate some proof of payment for drugs administered in 2004, I have been only able to find one credit card bill documenting payments made in 2003. The copy of the invoice is attached. I have looked diligently for additional supporting documents and have made numerous telephone inquiries.

7. My understanding is that the information I seek is either no longer available or is in storage and would be very difficult to locate in a timely fashion.

8. In addition, during 2003, Theresa paid for much of her medical care with her own credit cards and by her own checks. I cannot locate any of this information for the reasons stated earlier.

9. Since our supplemental insurance only provided coverage after we paid for the first Four Thousand Dollars (\$4000.00) in medical care, I am certain that many of the medications listed in 2003 were paid for us out of pocket.

I declare under penalty of perjury that the foregoing is true and correct.

Date: June 23, 2011

Thomas Trusky
Thomas Trusky

AMERICHOICE F C U
20 SPORTING GREEN
MECHANICSBURG PA 17050-2392



CARD NUMBER

PLEASE SUBMIT ADDRESS CHANGES ON THE DETACHABLE ENVELOPE FLAP ONLY.

CLOSING DATE	NEW BALANCE	MINIMUM PAYMENT	PAYMENT DATE	AMOUNT OF PAYMENT ENCLOSED
06/13/03	[REDACTED]	[REDACTED]	07/08/03	\$ [REDACTED]

THOMAS R TRUSKY
332 SUSQUEHANNA ST
FOREST CITY PA 18421-1308

MAKE CHECK PAYABLE TO:

AMERICHOICE F.C.U.
PO BOX 67001

HARRISBURG, PA 17106-7001

07/08/03

FAX # 215-230-8785

01 [REDACTED] 00000000 00074503 3

PLEASE RETURN THIS PORTION TO ENSURE PROPER CREDIT

DO NOT STAPLE CHECK

SEND INQUIRIES TO:

AMERICHOICE F C U
PO BOX 60070
HARRISBURG PA 17106
(800) 433 0505 NATL 800
(717) 697 3474 CARD COORD

REFERENCE NUMBER	MCC CODE	POSTING DATE	TRANS DATE	DESCRIPTION	AMOUNT
24226383135360531585325	5411	5 16	5 15	WM SUPERCENTER	41.29
24445003136604264438535	5411	5 18	5 15	DICKSON CITY PA	38.73
24610433136010180294507	5200	5 18	5 15	WEGMANS #076 SE1	38.97
24435653136236000018976	8062	5 18	5 16	SCRANTON PA	
24435653137364905682602	5964	5 18	5 16	THE HOME DEPOT 4118	
24435653141286624282014	8011	5 22	5 20	DICKSON CITY PA	
24445003142607092164225	5411	5 23	5 21	MARTIAN COMMUNITY HOSP	
24164053142378000067876	5542	5 23	5 21	CARBONDALE PA	25.31
24435653142236000016477	8062	5 23	5 22	MEDCO HEALTH FT WORTH	75.13
24158383145607907670770	8099	5 25	5 23	800-888-7010 TX	75.13
24158383145607907670853	8099	5 25	5 23	PHYSICIANS HEALTH OBGYN	
24445003149610436472315	5411	5 30	5 28	SCRANTON PA	
24164053149837000004042	5541	5 30	5 28	WEGMANS #076 SE1	14.71
24445003154612874577359	5411	6 04	6 02	EXXONMOBIL75 04694584	20.00
24164053154837000004838	5541	6 04	6 02	CHILDS PA	20.00
24435653155236000017834	8062	6 05	6 04	WEGMANS #076 SE1	36.72
24717053156641561122157	7399	6 05	6 04	SCRANTON PA	36.71
				EXXONMOBIL75 04694584	30.48
				CHILDS PA	21.00
				MARTIAN COMMUNITY HOSP	49.99
				CARBONDALE PA	21.00
				N-E PENNSYLVANIA TELEPHON	30.55
				FOREST CITY PA	89.40

AVERAGE DAILY BALANCE
SUBJECT TO FINANCE CHARGE*

PERIODIC RATE

CORRES APR

FINANCE CHARGE

ANNUAL PERCENTAGE RATE

ACCOUNT SUMMARY

MINIMUM PAYMENT

PREVIOUS BALANCE

PAST DUE

PURCHASES

OVERLIMIT AND FEES

CASH

PAYMENTS

CREDITS

INSURANCE

MY TOTAL OUT OF POCKET EXPENSE FOR
TERESA WAS 2,051.83 BY CHECK AND
CREDIT CARD. TO REACH THE 4,000.00
WE HAD TO INUR ADDITIONAL
MEDICAL EXPENSE OF 1,948.07 FOR A TOTAL
BLUE CROSS TO THEN PAY FOR ALL MEDICAL EXPENSE
THROUGH MEDICARE WHICH THEY DID NOT HAVE NO RECORD
OF HER CREDIT CARD STATEMENTS OR CHECKING TO VERIFY THE ADDITIONAL
1,948.07

**MUST BE POSTMARKED
BY JULY 1, 2011**

AWP TRACK 2 SETTLEMENT
MEDICARE PART B CLAIM FORM

IF YOU DO NOT MAKE ANY CHANGES
TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

FOR OFFICIAL USE ONLY

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Section A: Patient Information

Please review the preprinted information below and fill in any missing information. If you need to make corrections, please make them in the space provided.



* 2 0 0 9 5 * -001

THERESA TRUSKY
335 SUSQUEHANNA ST
FOREST CITY PA 18421

If the preprinted address to the left is incorrect
or out of date, OR if there is no preprinted data
to the left, check this box and print the patient's
current name and address

Name: _____

Address: _____

City: _____

State: ____ Zip Code: _____

(_____) _____ - _____
Daytime Telephone Number

Please review the information printed on this claim form carefully.

- **If you make any changes:** You must sign and return this claim form.
- **If you do not make any changes:** Do not return this claim form. A check will be automatically mailed to you.

Section B: Patient Representative Information

If you are the patient, DO NOT complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the patient listed above.

Representative's Name: _____ Relationship to Patient: _____

Representative's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Telephone Number: (_____) _____ - _____

Evening Telephone Number: (_____) _____ - _____

**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
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**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
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Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.

Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	Date Drug Received	Amount Paid Out-of-Pocket
1	ADENOSINE	10/29/2003	\$44.64
2	DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE	12/5/2003	\$366.26
3	EPOGEN	12/1/2003 0:00	72.80
4	EPOGEN	12/26/2003	72.80
5	EPOGEN	8/4/2003	72.80
6	EPOGEN	8/11/2003	72.80
7	NEULASTA	9/9/2003	\$69.82
8	NEULASTA	9/30/2003	\$69.82
9	EPOGEN	10/20/2003	72.80
10	EPOGEN	10/27/2003	72.80
11	NEULASTA	10/21/2003	\$418.92
12	EPOGEN	7/7/2003	72.80
13	NEULASTA	7/15/2003	\$69.82
14	EPOGEN	9/8/2003	72.80
15	NEULASTA	2/2/2004	519.20
16	NEULASTA	2/23/2004	519.20
17	DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE	2/20/2004	\$583.18
18	EPOGEN	2/12/2004	\$94.08
19	EPOGEN	10/13/2003	72.80
20	NEUPOGEN	7/1/2004	\$68.88

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Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	Date Drug Received	Amount Paid Out-of-Pocket
21	EPOGEN	7/2/2004	\$94.08
22	EPOGEN	7/9/2004	\$94.08
23	EPOGEN	7/30/2004	\$94.08
24	EPOGEN	4/8/2004	\$94.08
25	EPOGEN	6/18/2004	\$94.08
26	EPOGEN	6/25/2004	\$94.08
27	EPOGEN	8/6/2004	\$94.08
28	EPOGEN	8/13/2004	\$94.08
29	EPOGEN	8/20/2004	\$141.12
30	EPOGEN	8/27/2004	\$141.12
31	EPOGEN	1/23/2004	\$94.08
32	NEUPOGEN	6/28/2004	\$68.88
33	NEUPOGEN	6/29/2004	\$68.88
34	NEUPOGEN	6/30/2004	\$68.88
35	EPOGEN	6/4/2004	\$94.08
36	EPOGEN	6/11/2004	\$94.08
37	EPOGEN	3/11/2004	\$94.08
38	EPOGEN	3/19/2004	\$94.08
39	NEULASTA	1/12/2004	519.20
40	DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE	1/9/2004	\$583.18

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Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.

Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	Date Drug Received	Amount Paid Out-of-Pocket
41	DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE	1/30/2004	\$583.18
42	EPOGEN	1/16/2004	\$94.08
43	SODIUM CHLORIDE	10/29/2004	\$0.44
44	EPOGEN	10/29/2004	\$139.44
45	EPOGEN	10/14/2004	\$139.44
46	NEULASTA	3/29/2004	519.20
47	DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE	3/26/2004	\$583.18
48	EPOGEN	3/5/2004	\$94.08
49	EPOGEN	12/30/2004	\$139.44
50	SODIUM CHLORIDE	12/30/2004	\$0.44
51	SODIUM CHLORIDE	10/1/2004	\$0.44
52	EPOGEN	10/1/2004	\$139.44
53	EPOGEN	11/30/2004	\$139.44
54	EPOGEN	12/23/2004	\$139.44
55	SODIUM CHLORIDE	9/24/2004	\$0.44
56	EPOGEN	9/24/2004	\$139.44
57	ALCOHOL INJECTION	12/30/2004	\$61.56
58	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	12/30/2004	\$0.2
59	MANNITOL	12/30/2004	\$0.58
60	CISPLATIN	12/30/2004	\$10.85

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Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

Medicare Part B Purchase Information Chart			
	COLUMN A	COLUMN B	COLUMN C
61	SODIUM CHLORIDE	12/10/2004	\$0.44
62	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	11/12/2004	0.20
63	SODIUM CHLORIDE	11/12/2004	\$0.44
64	EPOGEN	11/12/2004	\$139.44
65	SODIUM CHLORIDE	9/17/2004	\$0.44
66	EPOGEN	9/17/2004	\$139.44
67	EPOGEN	10/8/2004	\$139.44
68	ALCOHOL INJECTION	12/10/2004	\$61.56
69	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	12/10/2004	0.20
70	MANNITOL	12/10/2004	\$0.58
71	CISPLATIN	12/10/2004	\$10.85
72	EPOGEN	12/10/2004	\$139.44
73	ALCOHOL INJECTION	12/17/2004	\$61.56
74	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	12/17/2004	\$0.2
75	CISPLATIN	12/17/2004	\$10.85
76	MANNITOL	12/17/2004	\$0.58
77	EPOGEN	12/17/2004	\$139.44
78	SODIUM CHLORIDE	10/8/2004	\$0.44
79	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	11/19/2004	0.20
80	SODIUM CHLORIDE	11/19/2004	\$0.44

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Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.

Medicare Part B Purchase Information Chart

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Section C Continued

Look carefully at the list of covered drugs found on Attachment A of the Notice. Check the chart above to make sure it contains all of the covered drugs you were administered or filled a prescription for as a Medicare recipient from January 1, 1991 through January 1, 2005. If it does not, you may add those drugs to the chart below.

- Only add drugs if you were responsible for paying a percentage co-payment as a Medicare Part B recipient.
- You are not eligible for a check if a) supplemental insurance covers your entire obligation for co-payment or b) you were responsible for making only flat co-payments.
- Flat co-payments do not vary with the cost of the drug. If your supplemental insurance covered only part of your percentage co-payment obligation, you are still eligible.

In order to add drugs to the chart below:

1. Enter the name of any additional drugs in Column A;
2. Enter dates of administration in Column B;
3. Enter the amount paid in Column C; and
4. Provide one of the following acceptable proofs of a percentage co-payment for each additional covered drug:
 - (1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or
 - (2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid part of the cost of one of the drugs (other than a flat co-payment) at least once; or
 - (3) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the covered drugs; or
 - (4) A notarized statement signed by you indicating you made or are obligated to make a percentage co-payment for the covered drugs from January 1, 1991 through January 1, 2005, including the total of all percentage co-payments for the drugs during the time period; or
 - (5) Records from your pharmacy showing that you made percentage co-payments for the covered drugs purchased from January 1, 1991 through January 1, 2005.

Additional Medicare Part B Purchase Information Chart

	COLUMN A Name of Drug	COLUMN B Date of Administration	COLUMN C Amount Paid Out-of-Pocket
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

-- ATTACH ADDITIONAL PAGES IF NEEDED --



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**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section D: Sign and Date Your Claim Form

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I made a percentage co-payment for one or more of the drugs as indicated in this claim form at some time during the period from January 1, 1991 through January 1, 2005. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.

Signature: _____

Print Name: _____

Date: ____ / ____ / ____

Section E: Mail Your Claim Form

If you did not make any changes to this document, you do not need to return this Claim Form.

Claim Forms that have been changed, along with proof of payment, must be postmarked by **July 1, 2011** and mailed to:

AWP Track 2 Settlement Administrator
P.O. Box 2417
Faribault, MN 55021-9117

If you have any questions, please call 1-877-465-8136 or visit the website at www.AWPTrack2Settlement.com.

REMINDER:

If you made changes to any information contained in Sections A, B, or C:

You must sign and return this claim form.

If you did not make any changes to the information printed on the claim form:

***Do not return this claim form.
A check will be automatically mailed to you.***



CERTIFICATE OF SERVICE BY LEXISNEXIS FILE & SERVE
Docket No. MDL 1456

I, Steve W. Berman, hereby certify that I am one of plaintiffs' attorneys and that, on June 24, 2011, I caused copies of **AFFIDAVIT OF THOMAS TRUSKY ON BEHALF OF ESTATE OF THERESA TRUSKY** to be served on all counsel of record by causing same to be posted electronically via LEXIS-Nexis File & Serve.

/s/ Steve W. Berman

Steve W. Berman